Supreme Court, U.S.
FILED

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No. OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1995

JERRY CANNON, Individually, and on behalf of the Estate of Phyllis Cannon, Deceased,

Petitioner,

v.

GROUP HEALTH SERVICE OF OKLAHOMA, INC., d/b/a BLUE CROSS & BLUE SHIELD OF OKLAHOMA, INC.; GHS HEALTH MAINTENANCE ORGANIZATION, d/b/a BLUE LINCS HMO,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. Whether the federal constitution requires a legislatively enacted scheme of compensation to provide a quid pro quo for the common-law or state-law remedies it replaces?

II. Whether this Court should enter an order granting certiorari, vacating the judgment below, and remanding this case to the Tenth Circuit for reconsideration in light of this Court's intervening decision in *Varity Corp. v Howe*, ___U.S.___, 116 S.Ct. 1065, ___ L.Ed.2d ___ (1996)?

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PETITION FOR WRIT OF CERTIORARI

Petitioner Jerry Cannon petitions for a writ of certiorari to review a ruling of the United States Court of Appeals for the Tenth Circuit in this case. The Tenth Circuit held Mr. Cannon could not bring a state-based claim for wrongful death against respondents, even though the refusal to authorize necessary life-saving treatment was wrongful and in bad faith. The Tenth Circuit found the provisions of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, effectively granted respondents, for-profit insurance carriers providing health insurance to Mr. Cannon's wife through her employer, immunity from a state claim for damages. The court of appeals found the immunity despite the fact ERISA provided Mr. Cannon no remedy. The Tenth Circuit noted this Court has not yet decided the issue of the constitutionality of a legislative scheme of compensation which abrogates common-law and state-law rights without also providing a reasonable alternative remedy. The Tenth Circuit's ruling in this case preceded this Court's decision in *Varity Corp. v. Howe*, ___U.S.___, 116 S.Ct. 1065, ___ L.Ed.2d ___ (1996) by 19 days.

OPINION BELOW

The opinion of the court of appeals (App. 1a) is reported at 77 F.3d 1270 (10th Cir. 1996). The opinions of the United States District Court for the Western District of Oklahoma (App. 19) are not reported.

JURISDICTION

The judgment of the court of appeals was entered on February 28, 1996. No rehearing was sought. This petition is being filed within 90 days after entry of judgment. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

The principal statutes and regulations involved in this case are reproduced in the appendix to this petition.

STATEMENT OF THE CASE

A. The History and Structure of the Employees Retirement Income Security Act (ERISA).

ERISA establishes a scheme through which employees may seek redress from those who do not fulfill their obligations in the management of employee benefit plans. This Court has addressed ERISA's intent and structure in several cases, including *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) and *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). Section 2(b) of the Act, 29 U.S.C. § 1001(b) provides the policy of the Act is to protect interstate commerce and the interests of participants in employee benefit plan by requiring disclosure and reporting of financial and other information and by establishing standards of conduct, responsibility, and obligation for fiduciaries and by providing for appropriate remedies, sanctions, and ready access to the Federal

courts. Section 502(a) of the Act, 29 U.S.C. § 1132(a), provides the structure of the civil enforcement scheme established by the Act. The Act seeks to abrogate traditional common-law rights of participants and beneficiaries and replace them with its own enforcement scheme. The Act specifically authorizes a participant or beneficiary to file a civil action to "obtain other appropriate equitable relief" not spelled out in the Act. Section 502(a)(30).

The legislative history of the Act demonstrates Congress intended federal courts to develop federal common law in fashioning the Act. One of the principal authors stated it was also intended that a body of Federal substantive law be developed by the courts to deal with the issues involving rights and obligations under the Act. 120 Cong.Rec. 29942 (1974); The other principal author emphasized suits involving beneficiaries' rights would be regarded as arising under the laws of the United States, in similar fashion to those brought under § 301 of the Labor Management Relations Act. *Id.* at 29933.

B. This Litigation.

Petitioner's wife, Phyllis Cannon, was diagnosed with acute myeloblastic leukemia in September, 1991. At that time, her health insurance was provided by respondents through a health care plan created by respondents and furnished by Mrs. Cannon's employer, Hendershot Tool Company. Mrs. Cannon was treated with chemotherapy and her leukemia went into remission. Respondents paid for the treatment.

In August, 1992, Mrs. Cannon's treating physician, Dr. Ruben Saez, recommended she undergo an autologous bone marrow transplant ("ABMT"), a treatment costing approximately $200,000. Dr. Saez advised Mrs. Cannon that without the ABMT, her chance of cure was "zero." On August 10, 1992, Dr. Saez sought preauthorization from respondents to cover the cost of the ABMT. On August 11, 1992, respondents denied preauthorization, contending the treatment was experimental during a first remission of leukemia. Dr. Saez requested respondents to reconsider his request and submitted medical literature establishing ABMT was not experimental. He also advised respondents of the urgency of the request and that it was imperative the treatment be completed before any cancer recurrence.

On August 21, 1992, respondents again refused to preauthorize the ABMT. The Cannons persisted in their efforts at reconsideration and on September 21, 1992, the respondents reversed their decision and agreed to authorize the ABMT. Notification of the decision did not reach Mrs. Cannon until October 10, 1992, in the form of a letter dated September 28, 1992. By that time, Mrs. Cannon was no longer in remission and could no longer receive any benefit of ABMT. She was admitted to the hospital on October 12, 1992, and remained there until her death on November 21, 1992.

On December 30, 1992, Mr. Cannon filed this action in Oklahoma state court for damages, alleging respondents either negligently or in bad faith failed to provide her with her only chance for a cure. Respondents filed a Notice of Removal to the U.S. District Court for Western District of Oklahoma. Mr. Cannon moved to remand. The

district court denied the remand and entered summary judgment in favor of respondents, concluding Mrs. Cannon's group health insurance coverage was an ERISA plan and that all of Mr. Cannon's state common law and statutory claims were preempted by ERISA. The district court gave Mr. Cannon an opportunity to move for permission to file an amended complaint. After Mr. Cannon filed a motion to amend, the district court concluded the proposed new claims could not withstand a motion to dismiss and denied the motion and entered judgment for respondents. A timely appeal was filed and on February 28, 1996, the Tenth Circuit affirmed the district court's judgment dismissing all claims.

C. The Court of Appeals Opinion.

In the Tenth Circuit, Mr. Cannon argued ERISA may not preempt state common-law rights if no alternative remedy is provided by the Act. Although the court of appeals agreed Mr. Cannon had no available remedy under ERISA, it found that fact had no bearing on its preemption analysis, based on this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). The court of appeals reasoned the "proper focus for preemption analysis should be on the nature of the claim for relief," not whether the plaintiff has a potential remedy under ERISA.

The Tenth Circuit found no constitutional barrier to ERISA's abrogation of rights without providing any remedy as occurred in the present case. The circuit court found no violation of Mr. Cannon's right to access justice

because a "fundamental right to access justice has yet to be defined."

Finally, the court of appeals found the doctrine of equitable estoppel did not apply to this case. The circuit court determined it need not decide whether equitable estoppel is available in the ERISA context, concluding Mr. Cannon had not stated an equitable estoppel claim because of an absence of misrepresentation of any term of the plan upon which Mrs. Cannon detrimentally relied.

REASONS FOR GRANTING THE WRIT

I. THIS CASE PRESENTS AN IMPORTANT QUESTION OF FEDERAL LAW WHICH HAS NOT BEEN, BUT SHOULD BE, SETTLED BY THE COURT.

The Oklahoma Constitution assures its citizens a "certain remedy afforded for every wrong and for every injury to person, property or reputation," Okla. Const. Art. 2, § 6, and assures its citizens none "shall be deprived of life, liberty, or property, without due process of law." Okla. Const. Art. 2, § 7. Oklahoma decisional law requires insurers to act fairly and in good faith with its insureds and provides for the availability of compensatory and punitive damages for breaches of those obligations. *See, Buzzard v. Farmers Ins. Co., Inc.*, 824 P.2d 1105 (Okla. 1992); *Timmons v. Royal Globe Ins. Co.*, 782 P.2d 1357 (Okla. 1989); and *Christian v. American Home Assurance Co.*, 577 P.2d 899 (Okla. 1977). Thus, absent preemption of common law, petitioner would have a right to seek legal redress for the wrongful conduct of respondents.

The Tenth Circuit concluded petitioner has no remedy in this case. "The district court concluded Mr. Cannon had no available remedy under ERISA, and we agree." *Cannon v. Group Health Service of Oklahoma, Inc.*, 77 F.3d 1270, 1274 (10th Cir. 1996) (App. 1). However, the Tenth Circuit found the absence of any remedy pursuant to ERISA had no bearing on its preemption analysis. *Id.* at 11. Additionally, the court of appeals decision acknowledged this Court has not decided this issue. *Id.* at 1274.

The facts of this litigation present to this Court an opportunity to resolve an important question of federal law: Whether the federal constitution requires a legislatively enacted scheme of compensation to provide a quid pro quo for the common-law or state-law remedies it replaces.

This issue of whether a reasonable quid pro quo is constitutionally required in legislatively created compensation schemes has drawn this Court's attention in several cases, but ultimately none provided sufficient facts to allow the Court to reach the issue for determination. For example, in *New York Central R. Co. v. White*, 243 U.S. 188 (1917), the Court analyzed the propriety of the abolition of tort suits by employees against employers for workplace injuries as a part of New York's workers' compensation statutes. While the Court suggested due process might preclude a state from abolishing common law rights of action "without providing a reasonable just substitute," *Id.* at 201, it concluded the issue need not be addressed since the statute's non-fault compensation scheme, which removed several tort defenses against recovery, constituted an adequate alternative. *Id.*

Subsequently in *Duke Power Co. v. Carolina Environmental Study Group*, 438 U.S. 59, 98 S.Ct. 2620, 57 L.Ed.2d 595 (1978) the issue was raised once again. While the Court noted it was not clear whether the Due Process Clause requires legislative compensation schemes to "either duplicate the recovery at common law or provide a reasonable substitute remedy," *Id.* at 88, it found no need to resolve the question in that case since the Act under review (the Price-Anderson Act) provided "a reasonably just substitute for the common-law or state tort law remedies it replaces." *Id.*

The question was briefly discussed again in *PruneYard Shopping Center v. Robins*, 447 U.S. 74, 100 S.Ct. 2035, 64 L.Ed.2d 741 (1980), where this Court affirmed a decision by the California Supreme Court which required access to a shopping center for exercise of expression and petition right under the California Constitution. This Court held the lower court's ruling did not violate the shopping center owner's rights under the First, Fifth and Fourteenth Amendments. While the Court did not address the quid pro quo issue, Justice Marshall, concurring, noted the Court's decision did not need to reach it. Justice Marshall also noted, however, it was a live issue. "Indeed, our cases demonstrate that there are limits on governmental authority to abolish 'core' common-law rights, including rights against trespass, *at least without a compelling showing of necessity or a provision for a reasonable alternative remedy.*" (footnotes omitted) (emphasis added) *Id.* at 93-94. Justice Marshall concluded the "core" had not been approached in the case and, once again, the issue of requiring a reasonable alternative remedy did not receive full consideration by this Court.

The issue was once again raised, but not resolved, in *Fein v. Permanente Medical Group*, 474 U.S. 892, 106 S.Ct. 214, 88 L.Ed.2d 215 (1985). "Whether due process requires a legislatively enacted compensation scheme to be a quid pro quo for the common-law or state-law remedy it replaces, and if so, how adequate it must be, thus *appears to be an issue unresolved by this Court, and one which is dividing the appellate and highest courts of several States. The issue is important, and is deserving of this Court's review.*" *Id.* at 894-895 (White, dissenting) (emphasis added).

The Tenth Circuit decision affords review of this important issue in a way the previous cases did not. Here, there is no substitute, reasonable or otherwise, for the common-law remedies which ERISA was found to abrogate in petitioner's case.[1] This litigation presents a

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[1] The lack of remedy in this action is particularly aggravated by additional facts. The record below demonstrates the policy at issue here was a standard policy designed, marketed, sold, and administered by respondents which are for-profit, proprietary companies. No portion of the plan was self-insured, thus no claims were paid out of any funds created by the employer. Respondents' sales representative never mentioned ERISA to the decision makers at Mrs. Cannon's employer, Hendershot. When this action was filed, respondents advised an official at Hendershot, Henry Johnson, that Hendershot "could be held responsible" in this case by virtue of ERISA. (The action, however, was filed against respondents only and not the employer. Hendershot was never made a party to this litigation.) To allay any concerns Hendershot had about its own prospects for liability to the Cannons, respondents, just prior to his deposition, advised Mr. Johnson that if Hendershot was ever found liable in this case, respondents would indemnify Hendershot. Finally, Hendershot did not make the decision to deny Mrs. Cannon coverage for the ABMT. Indeed,

clearly delineated set of facts which allow this Court finally to resolve whether a quid pro quo is constitutionally required.

There are two constitutional barriers to the abrogation of common-law rights with no quid pro quo. First, is the Due Process Clause, discussed *infra*.

The second raises another important question of federal law not yet clearly decided by this Court: Whether inherent in the Constitution is a fundamental right to access justice. If so, that right clearly was violated in this case.

Article 40 of Magna Carta provided "to none will we sell, to none will we deny, to none will we delay right or justice." This bedrock doctrine was specifically embraced in the Oklahoma Constitution and is implicitly present in the Due Process Clause and the Ninth Amendment of the Federal Constitution. "The constitutional terms 'life, liberty, and property' do not derive their meaning solely from the provisions of positive law. They have a normative dimension as well, establishing a sphere of private autonomy which government is bound to respect." *PruneYard*, 447 U.S. at 93 (Marshall, concurring). A "fundamental constitutional right of access to the courts" was relied upon by the Court in reaching its holding in *Bounds v. Smith*, 430 U.S. 817, 828, 97 S.Ct. 1491, 1498, 52 L.Ed.2d 72 (1977).

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when Mr. Johnson learned the treatment had not been preauthorized, he called his insurance agent to find if there was anything he could do to get Mrs. Cannon the preauthorization. His efforts were unsuccessful.

This Court has recognized certain fundamental rights despite their lack of specific articulation in the constitution. *See, Griswold v. Connecticut,* 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965) (law prohibiting use of contraceptives is constitutional inpingement upon the right of marital privacy); *Roe v. Wade,* 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973) (right of privacy or a guarantee of certain areas or zones of privacy exists under Constitution); *Paul v. Davis,* 424 U.S. 693, 96 S.Ct. 1155, 47 L.Ed.2d 405, *rehearing denied,* 425 U.S.985, 96 S.Ct. 2194, 48 L.Ed.2d 811 (1976) (while no "right of privacy" is found in any specific guarantee of the Constitution, "zones of privacy" may be created by more specific constitutional guarantees); *Carey v. Population Services, Intern.,* 431 U.S. 678, 97 S.Ct. 2010, 52 L.Ed.2d 675 (1977) (right of personal privacy includes interest in independence in making certain important decisions such as marriage, procreation, contraception, family relationships, child rearing and education without unjustified government interference); *Katz v. U.S.,* 389 U.S. 347, 88 S.Ct. 507, 19 L.Ed.2d 576 (1967) (discussing a person's right to be left alone); *U.S. v. Guest,* 383 U.S. 745, 86 S.Ct. 1170, 16 L.Ed.2d 239 (1966) (finding right to interstate travel is constitutionally protected independent of the Due Process Clause); *Cruzan v. Director, Missouri Dep't. of Health,* 497 U.S. 261, 278-85, 100 S.Ct. 2842, 2851-55, 111 L.Ed.2d 224 (1990) (for purposes of case, Court assumed a competent person had constitutional right to refuse life-saving hydration and nutrition); *Planned Parenthood of Southeastern Pa. v. Casey,* 505 U.S. 833, 845-53, 112 S.Ct. 2791, 2804-08, 120 L.Ed.2d 674, 695-699 (1992) (discussing a woman's right to terminate her pregnancy as a fundamental right).

This Court is presented with a case in which ERISA purports to abrogate rights with no corresponding quid pro quo. One right, the right to access justice, is fundamental, existing traditionally since Magna Carta. In this case, petitioner has been denied. This court should decide the important issue of whether petitioner has suffered the loss of a fundamental right, and, if so, whether that loss can withstand constitutional scrutiny.

Under the Tenth Circuit decision, the employer has been protected and respondents have been protected, but the Cannons, who were meant to be protected, have not. This Court should determine whether the Due Process Clause alone or the Due Process Clause and Ninth Amendment serve as a barrier to such a result.

II. THE JUDGMENT OF THE TENTH CIRCUIT SHOULD BE VACATED AND REMANDED FOR RECONSIDERATION IN LIGHT OF THIS COURT'S INTERVENING RULING IN *VARITY CORP. V. HOWE.*

Nineteen days following the Tenth Circuit's opinion and judgment, this Court issued its decision in *Varity Corp. v. Howe*, ___ U.S. ___, 116 S.Ct. 1065, ___ L.Ed.2d ___ (1996), where the Court recognized the right of an individual participant in an ERISA plan to bring an action for breach of fiduciary duty. While the Tenth Circuit indicated it considered petitioner to have abandoned that theory on appeal, 77 F.3d at 1272, the court nonetheless addressed it long enough to note petitioner's initial claims were for breach of contract or a breach of fiduciary

duty, but that this Court and the Tenth Circuit had "consistently held these types of claims are preempted by ERISA," *Id.* at 1273, citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 133, 138-39; *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-3; *Pitman v. Blue Cross & Blue Shield of Okla.*, 24 F.3d 188, 121-22 (10th Cir. 1994) and *Kelso v. General American Life Ins. Co.*, 967 F.2d 388, 389-91 (10th Cir. 1992).

This Court, in *Varity Corp. v Howe*, found a breach of fiduciary duty not only actionable by a plan pursuant to § 409 of ERISA, it may also be the basis of an action filed by an individual beneficiary under the provisions of § 502 of the Act. While this Court's holding is alone sufficient reason for reconsideration by the court of appeals, the rationale of this Court's decision compels reconsideration. In discussing its decision, the Court noted ERISA's basic purpose, particularly as set forth in § 2(b) of the Act, is not violated by permitting equitable relief. "Given these objectives, it is hard to imagine why Congress would want to immunize breaches of fiduciary obligation that harm individuals by denying injured beneficiaries a remedy." ___ U.S. at ___, 116 S.Ct. at 1078, ___ L.Ed.2d at ___. That rationale applies equally to the present case. It is hard to imagine why Congress would want to immunize respondents from liability to petitioner for their wrongful conduct. The respondents saved $200,000.00 at the expense of Mrs. Cannon's life and if the circuit court opinion is allowed to stand, there will no remedy, no redress, no legal relief available to petitioner. It is truly difficult to imagine Congress intended such a result. To grant relief in the present case would not violate the purpose of the Act.

The Tenth Circuit was clearly troubled by this case. "Although moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted, we conclude the law gives us no choice but to affirm." (App. 2). In view of this Court's holding and reasoning in *Varity Corp. v. Howe*, if the Tenth Circuit is directed to reconsider its decision, it may now conclude the law indeed provides a choice other than to affirm. There is now a basis in law for granting petitioner relief. That relief should be preventing, on equitable grounds, the assertion of ERISA preemption in cases such as the present where the individual beneficiary would otherwise be left with no remedy. Such relief would be consistent with Congress' intent to protect employees through ERISA. This Court has recognized the legislative history of ERISA demonstrates Congress intended federal courts to develop federal common law in fashioning the additional "appropriate equitable relief." *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985), Justice Brennan (concurring). Justice Brennan noted one of the principal authors of the legislation stated that "[it] is also intended that a body of Federal Substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." (footnote omitted). 473 U.S. at 156. The other principal author also emphasized suits involving beneficiaries' rights "will be regarded as arising under the laws of the United States, in similar fashion to those brought under section 301 of the Labor Management Relations Act." (footnote omitted). *Id.*

In the present case, this Court may fashion federal substantive law to grant him relief. It need not be traditional equitable estoppel, or necessarily any traditional state common law remedy. In keeping with Congress' intent, it may be an addition to substantive law which fulfills the purpose of the Act. Refusing to allow respondents to assert ERISA preemption would be an appropriate remedy here.

This Court should grant certiorari, vacate the judgment below and order reconsideration in light of *Varity Corp. v. Howe.*

CONCLUSION

This Court should grant the petition for certiorari.

Respectfully submitted,

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May 28, 1996

PUBLISH

UNITED STATES COURT OF APPEALS

FOR THE TENTH CIRCUIT

JERRY CANNON, Individually and on behalf of the Estate of Phyllis Cannon, Deceased, Plaintiff-Appellant, v. GROUP HEALTH SERVICE OF OKLAHOMA, INC., d/b/a Blue Cross & Blue Shield of Oklahoma; GHS HEALTH MAINTENANCE ORGANIZATION, INC., d/b/a Blue Lincs HMO, Defendants-Appellees.	)	No. 94-6451

Appeal from the United States District Court
For the Western District of Oklahoma
D.C. No. CIV-94-159-A

(Filed Feb. 28, 1996)

Larry Alan Tawwater (Jo L. Slama and Terry T. Wiens with him on the briefs), McCaffrey & Tawwater, Oklahoma City, Oklahoma, for Plaintiff-Appellant.

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him on the briefs), J.R. Ebenstein Consultants, Valparaiso, Indiana, for Defendants-Appellees.

Before PORFILIO, and BRORBY, Circuit Judges; and HOLMES, District Judge.*

PORFILIO, Circuit Judge.

Jerry Cannon filed this action against Group Health Service of Oklahoma, Inc., d/b/a Blue Cross & Blue Shield of Oklahoma, and GHS Health Maintenance Organization, Inc., d/b/a Blue Lincs HMO (insurers) to recover damages for the death of his wife, Phyllis Cannon. After removal to federal court, the district court granted summary judgment for the insurers, holding Mr. Cannon's claims were preempted by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001 to 1461. The district court also denied Mr. Cannon's motion to amend his complaint, holding his new claims could not withstand a motion to dismiss. Mr. Cannon now appeals. Although moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted, we conclude the law gives us no choice but to affirm.

---

* Honorable Sven Erik Holmes, United States District Court Judge for the Northern District of Oklahoma, sitting by designation.

I

Phyllis Cannon was diagnosed with acute myeloblastic leukemia in September of 1991. She was treated with chemotherapy, and her leukemia went into remission. The insurers paid for this medical treatment. Mrs. Cannon's treating physician, Dr. Ruben Saez, recommended she undergo an autologous bone marrow transplant (ABMT), and on August 10, 1992, sought preauthorization from the insurers.

On August 11, 1992, the insurers denied preauthorization for the ABMT, contending the treatment was experimental during a first remission of leukemia. Dr. Saez requested the insurers reconsider his request and submitted medical literature in an attempt to demonstrate his proposed treatment was not experimental. Dr. Saez also informed the insurers his request needed urgent action because it was critical the ABMT be completed prior to any cancer recurrence.

On August 21, 1992, the insurers again denied preauthorization. The Cannons persisted in their request for reconsideration, and on September 21, 1992, the insurers reversed their decision and agreed to authorize ABMT. Unfortunately, Mrs. Cannon was not notified until October 10, 1992, in a letter dated September 28, 1992. By that time, her leukemia had returned and she could no longer beneficially receive ABMT, and none was ever administered. She was admitted into the hospital on October 12, 1992, and died on November 21, 1992.

Mrs. Cannon was insured through her employer, Hendershot Tool Company. She chose health insurance coverage through Blue Lincs HMO, one of three options

of Hendershot's health insurance plan. When Mrs. Cannon was first diagnosed with leukemia in September 1991, the Blue Lincs HMO plan provided:

> The following services or procedures are not covered by BlueLincs HMO: . . . . (13) Organ transplants other than skin, cornea, bone, bone marrow and kidney.

However, four months after Mrs. Cannon's diagnosis, effective January 1, 1992, Blue Lincs HMO issued an "Amendatory Rider" which specified.

> Preauthorization will be denied, and benefits will not be provided, for autologous bone marrow transplants. . . . Such as: acute leukemia in first remission; . . . .

The insurers claimed the Rider was only a clarification in their policy, not a change in coverage. These facts are not in dispute.

Initially, on December 30, 1992, Mr. Cannon filed suit in Oklahoma state court to recover damages for the death of his wife. He alleged her insurers either negligently or in bad faith refused to authorize the ABMT for seven weeks, at a time when it offered Mrs. Cannon her only chance of a cure for her leukemia. The insurers filed a Notice of Removal to federal court asserting Mrs. Cannon's health insurance plan was an employee welfare benefit plan within the meaning of ERISA providing exclusive federal jurisdiction.

Although Mr. Cannon moved to remand, that motion was denied, and the district court granted the insurers' subsequent motion for summary judgment. The district court concluded Mrs. Cannon's group health insurance

coverage was an ERISA plan; and, as such, it preempted all of Mr. Cannon's state common law and statutory claims. Preemption, the court held, was required because the state claims related to the ERISA plan and did not fall within ERISA's savings clause. These conclusions notwithstanding, the district court gave Mr. Cannon the opportunity to file an amended complaint.

Thereafter, the district court denied Mr. Cannon's motion to amend his complaint because his new claims could not withstand a motion to dismiss, making amendment futile. Mr. Cannon's amended complaint stated three claims under ERISA: (1) for benefits under 29 U.S.C. § 1132(a)(1)(B); (2) for equitable relief under 29 U.S.C. § 1132(a)(3); and (3) for breach of fiduciary duty pursuant to 29 U.S.C. § 1132(a)(2). Mr. Cannon's complaint also brought a claim pursuant to the Lanham Trade-Mark Act, 15 U.S.C. §§ 1051 to 1127.

In its holding, the court disposed of Mr. Cannon's claims for benefits and equitable relief under ERISA because Mrs. Cannon never incurred medical expenses nor received ABMT. The court stated:

> [It] carefully considered plaintiff's argument but stands unpersuaded that he can sue under subsection 1132(a)(1) or (3) to recover anything other than payment for medical expenses actually incurred, when that is the benefit provided by the plan. Plaintiff cites no legal authority for the proposition that a person may sue to recover the value of a service that would have been a benefit of the plan if the plan's terms had been satisfied.

The court also concluded Mr. Cannon's breach of fiduciary duty claim was unavailing because beneficiaries cannot recover compensatory damages for any such breach, stating: "A fiduciary is liable under ERISA, if at all, to the plan and not to the beneficiary." Finally, the court held Mr. Cannon failed to state a claim under the Lanham Trade-Mark Act. Mr. Cannon has not appealed the district court's decision on this issue; therefore, we deem it abandoned and do not address it.

II

A

Mr. Cannon raises three issues on appeal. First, he argues ERISA does not preempt state causes of action where ERISA does not provide a remedy. Mr. Cannon contends ERISA preemption in this context is inconsistent with the policies behind ERISA, the McCarran-Ferguson Act, and the Tenth Amendment. Second, Mr. Cannon argues application of ERISA to preempt state laws where ERISA provides no remedy violates his fundamental right to access justice. Third, Mr. Cannon maintains the federal common law includes the concept of equitable estoppel allowing him to assert his claim.

This court reviews the district court's interpretation of ERISA de novo. *St. Francis Regional Medical Center v. Blue Cross & Blue Shield of Kan., Inc.*, 49 F.3d 1460, 1462 (10th Cir. 1995); *National Elevator Indus., Inc. v. Calhoon*, 957 F.2d 1555, 1557 (10th Cir.), *cert. denied*, 506 U.S. 953 (1992). Determining whether a particular state law action is preempted by ERISA depends on the interrelationship of three ERISA statutory provisions – the preemption

clause, the savings clause, and the deemer clause. The preemption clause, 29 U.S.C. § 1144(a), provides:

> Except as provided in subsection (b) of this section [the savings clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .

The savings clause, 29 U.S.C. § 1144(b) (2) (A), reads:

> Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

The deemer clause, 29 U.S.C. § 1144(b) (2) (B), states:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

The interpretation and analysis of these three provisions has been a recurrent theme in both the Supreme Court and this court.

The seminal Supreme Court ERISA preemption case is *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). In *Pilot Life*, the Court addressed the appropriate inquiry for determining whether a particular state law claim was preempted under ERISA. A court must analyze whether

the state statutory or common law actions asserted in the plaintiff's complaint " 'relate to' an employee benefit plan and therefore fall under ERISA's express pre-emption clause." *Id.* at 47. The Court noted the preemption clause had an "expansive sweep," and must be given its "broad common sense meaning." *Id.*

More recently, the Court has elaborated:

> The pre-emption clause is conspicuous for its breadth. Its deliberately expansive language was designed to establish pension plan regulation as exclusively a federal concern. The key to § 514(a) is found in the words relate to. Congress used those words in their broad sense, rejecting more limited pre-emption language that would have made the clause applicable only to state laws relating to specific subjects covered by ERISA. . . .
>
> A law relates to an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan. Under this broad common-sense meaning, a state law may relate to a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect. Pre-emption is also not precluded simply because a state law is consistent with ERISA's substantive requirements.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138-39 (1990) (citations and quotation marks omitted). A common law cause of action which "relates to" ERISA is preempted unless it falls within one of the exceptions to § 514(a).

Mr. Cannon's initial claims were for breach of contract or a breach of fiduciary duty cause of action related to the improper processing of Mrs. Cannon's benefit claim for ABMT. Both the Supreme Court and this court have consistently held these types of claims are preempted by ERISA. *See, e.g., Pilot Life,* 481 U.S. at 57 (common law tort and contract actions asserting improper processing of a claim for benefits preempted by ERISA); *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 62-3 (1987) (common law tort and contract claims are preempted); *Pitman v. Blue Cross & Blue Shield of Okla.,* 24 F.3d 118, 121-22 (10th Cir. 1994) (tortious breach of contract claim preempted); *Kelso v. General American Life Ins. Co.,* 967 F.2d 388, 389-91 (10th Cir. 1992) (common law breach of contract action preempted). *But see Mackey v. Lanier Collection Agency & Serv.,* 486 U.S. 825, 841 (1988) (general Georgia garnishment statute not preempted by ERISA; but specific provision referring to ERISA is preempted); *Guidry v. Sheet Metal Workers Nat. Pension Fund,* 39 F.3d 1078, 1083-86 (10th Cir. 1994) (en banc) (general Colorado garnishment statute not preempted by ERISA), *cert. denied,* 115 S. Ct. 1691 (1995).

Mr. Cannon does not really dispute the fact his claims would be preempted based on these precedents. Instead, he argues a question of first impression exists whether ERISA may preempt state common law claims if no alternative remedy is possible under ERISA. The district court concluded Mr. Cannon had no available remedy under ERISA, and we agree. However, even assuming Mr. Cannon did not have any remedy pursuant to ERISA, we do not believe this fact has any bearing on our preemption analysis.

Mr. Cannon is correct the Supreme Court has not addressed this precise issue. He has skillfully crafted an argument, based on a variety of different cases, that by implication preemption only is appropriate when ERISA provides a remedy. However, none of the cases he cites stand for the broad proposition an exception to ERISA's express preemption clause exists when ERISA provides no remedy.

Mr. Cannon is effectively asking us to rewrite ERISA to craft such an exception. Although there are sound reasons why such an exception is appropriate, the Congress, and not this court, is the appropriate forum for such policy arguments.

While the Supreme Court has not addressed this issue, we have. In dicta, we have noted the unavailability of a remedy under ERISA is not germane to preemption analysis.

> Finally, plaintiffs suggest that a definition of "participant" which excludes them will leave them without a remedy, inasmuch as their state law claims were held preempted by ERISA. Preemption is not at issue in this case, and we do not address it. However, we note the fact that a state law claim may be preempted does not necessarily mandate that there be an ERISA remedy. *See Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1333 (5th Cir.) ("While we are not unmindful of the fact that our interpretation of the preemption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans, the lack of an ERISA remedy does not affect a pre-emption analysis."), *cert. denied*, ___ U.S. ___, 113 S. Ct. 812,

> 121 L.Ed.2d 684 (1992); *Cromwell v. Equicor HCE Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991) ("Nor is it relevant to an analysis of the scope of federal preemption that appellants may be left without a remedy."), *cert. denied*, ___ U.S. ___, 113 S. Ct. 2, 120 L.Ed.2d 931 (1992); *Hospice of Metro Denver, Inc. v. Group Health Ins.*, 944 F.2d 752, 755 (10th Cir. 1991) ("We are aware that preemption normally is not dependent on the availability of ERISA remedies.").

Raymond v. Mobil Oil Corp., 983 F.2d 1528, 1537-38 (10th Cir.), *cert. denied*, 114 S. Ct. 81 (1993) (footnote omitted).

Further, the Supreme Court has clarified Congress intended the civil enforcement mechanisms of ERISA to be exclusive, and this legislative policy choice must be respected. In *Pilot Life*, the Court explained:

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Pilot Life, 481 U.S. at 54. We see no reason why this calculation should differ because of the unavailability of ERISA remedies. Mr. Cannon has failed to explain why one class of potential plaintiffs – those without available ERISA remedies – should be entitled to state common law and statutory remedies which would remain unavailable

to another class of plaintiffs – those with alternative ERISA remedies. The proper focus for preemption analysis should be on the nature of the claim for relief, not on whether a particular plaintiff has a potential remedy under ERISA.

B

Next, Mr. Cannon crafts an argument out of a creative reading of the deemer and savings clauses. He suggests his claims fall within the savings clause because they regulate insurance. There are numerous problems with this analysis, however.

We have found no case which stands for the proposition an insurance company which contracts through an employer to supply insurance to an employee benefit plan should be deemed an insurance company. The savings clause indicates Congress sought to allow states to regulate the business of insurance. In turn, the deemer clause reveals Congress' fear the states would overzealously deem employee benefit plans as insurance for the purpose of regulating them. Mr. Cannon's argument is in direct contradiction to this provision because there is no doubt Mrs. Cannon's plan was an employee benefit plan within the meaning of ERISA.

Mr. Cannon's broad policy argument related to the McCarran-Ferguson Act is equally inapposite. In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 742-44 (1985), the Court adopted the definition of "business of insurance" from this Act to help determine whether a state law falls within the savings clause. Unfortunately for Mr. Cannon, his claims arise from generally applicable

common law principles which do not specifically regulate insurance within the meaning of the savings clause. *FMC Corp. v. Holliday*, 498 U.S. 52, 57-8 (1990). Therefore, even if Mrs. Cannon's health plan was considered "insurance," the savings clause would not save Mr. Cannon's claims from the application of the preemption clause.

C

Finally, Mr. Cannon argues the Tenth Amendment supports his theory no remedy equals no preemption. However, he has failed to indicate how the Tenth Amendment precludes Congress from exercising its Commerce Clause authority to enact ERISA. ERISA substantially affects commerce to a greater degree than what has recently concerned the Supreme Court in this area, regardless of the Tenth Amendment. *See United States v. Lopez*, ___ U.S. ___, 115 S. Ct. 1624 (1995) (holding Gun Free School Zones Act of 1990, 18 U.S.C. § 922(q)(1)(A), exceeds Congress' Commerce Clause authority). Mr. Cannon's broad policy arguments concerning the reserved powers of the states are unavailing to his cause. We conclude the district court ruled correctly on this issue.

III

Mr. Cannon argues, if ERISA is applied to preempt Oklahoma law, he has suffered an unconstitutional denial of his right to access justice. Mr. Cannon locates this fundamental right in several sources. First, in the Fifth Amendment's Due Process Clause and the Ninth Amendment. He argues one of the Ninth Amendment's rights reserved to the people is the right to access courts for

redress. Mr. Cannon cites the Magna Carta in support of this proposition. "To none will we sell, to none will we deny, to none will we delay right to justice." Magna Carta, Art. 40. Second, he finds such a right in two cases. *Bounds v. Smith,* 430 U.S. 817 (1977); *Doe v. Puget Sound Blood Center,* 819 P.2d 370 (Wash. 1991) ("That justice which is to be administered openly is not an abstract theory of constitutional law, but rather is the bedrock foundation upon which rest all the people's rights and obligations."). Third, he argues such a right is implicit in numerous Supreme Court cases which determined federal regulatory law did not preempt state torts law. Mr. Cannon argues in these cases the Court was concerned with whether preemption would deprive a party of a remedy.

Although impressed with the inventiveness of this argument, we believe it is without substance. Simply put, a fundamental right to access justice has yet to be defined. The Supreme Court has carefully limited those rights considered part of the substantive component of liberty within the meaning of the Due Process Clauses of the Fifth and Fourteenth Amendments. *See generally Planned Parenthood of Southwestern Pa. v. Casey,* ___ U.S. ___, 112 S. Ct. 2791, 2804-08 (1992) (discussing a woman's right to terminate her pregnancy as a fundamental right); *Cruzan v. Director, Missouri Dep't of Health,* 497 U.S. 261, 278-85 (1990) (discussing the right to die as a fundamental right); *Bowers v. Hardwick,* 478 U.S. 186, 190-96 (1986) (discussing the right of homosexuals to engage in consensual sodomy as not a fundamental right).

Neither case Mr. Cannon cites supports this fundamental right to access justice. First, in *Bounds,* the Court

held "the fundamental right of access to the courts requires prison authorities to assist inmates in the preparation and filing of meaningful legal papers by providing prisoners with adequate law libraries or adequate assistance from persons trained in the law." 430 U.S. at 828. The fundamental right Mr. Cannon seeks is much broader than the Court's holding in *Bounds*. Second, in *Doe*, the Washington Supreme Court addressed whether the recipient of a blood transfusion contaminated with AIDS could compel the discovery of the name of the blood donor from the Blood Center. The court affirmed the trial court's conclusion the donor's name could be discovered. *Doe*, 819 P.2d at 373. We fail to see the relevance of *Doe* to Mr. Cannon's argument. Finally, the other cases involving federal preemption cited by Mr. Cannon are also inapposite.

IV

Last, Mr. Cannon argues the concept of equitable estoppel should apply here. He asserts federal courts have a duty to develop federal common law to supplement ERISA, and this court should look to state law to develop this federal common law. Mr. Cannon asserts the court in *National Companies Health Benefit Plan v. St. Joseph's Hosp. of Atlanta*, 929 F.2d 1558 (11th Cir. 1991), adopted the principle of equitable estoppel in ERISA cases. He urges equitable estoppel principles should apply here to prevent the insurers from benefitting from their unreasonable conduct.

Although Mr. Cannon relies upon *National Companies* for the general proposition a federal common law of

equitable estoppel should be applied in his case, the Eleventh Circuit concluded equitable estoppel could apply only under certain circumstances, explaining:

> In *Nachwalter v. Christie*, 805 F.2d 956, 960 (11th Cir. 1986), this court held that the federal common-law claim of equitable estoppel is not available to plaintiffs in cases involving oral amendments to or modifications of clear terms of employee benefit plans governed by ERISA. . . .
>
> In *Kane [v. Aetna Life Ins.*, 893 F.2d 1283, 1283, *cert denied*, 111 S. Ct. 232 (1990)], this court further clarified the scope of the holding in *Nachwalter*, "differentiat[ing] between oral amendments or modifications to a plan and oral *interpretations* of a plan." The court held that the federal common-law claim of equitable estoppel may be applied when an employee relies, to his detriment, on an interpretation of an ambiguous provision in a plan by a representative of that plan. . . . The rationale of *Kane* is equally applicable to informal written interpretations of an ERISA plan.

Id. at 1571-72 (citation omitted). The court applied its equitable estoppel rule to a written interpretation of an ERISA continuing coverage provision. *Id.* at 1572. In *National Companies*, the Eleventh Circuit identified five elements of a common-law claim of equitable estoppel: (1) the party to be estopped misrepresented material facts; (2) the party to be estopped was aware of the true facts; (3) the party to be estopped intended that the misrepresentation be acted on or had reason to believe the party asserting the estoppel would rely on it; (4) the party asserting the estoppel did not know, nor should it

have known, the true facts; and (5) the party asserting the estoppel reasonably and detrimentally relied on the misrepresentation. *Id.* (citing *Heckler v. Community Health Servs. of Crawford Cty., Inc.*, 467 U.S. 51, 59 (1984) and *Apponi v. Sunshine Biscuits, Inc.*, 809 F.2d 1210, 1217 (6th Cir.), *cert. denied*, 484 U.S. 820 (1987)).

The major distinction here which negates equitable estoppel is the absence of misrepresentation of any term of the plan triggering Mrs. Cannon's reasonable detrimental reliance. The controversy surrounding whether the plan would authorize ABMT had nothing to do with any misrepresentation; it simply was a disagreement over the proper interpretation of the terms of the plan. Although it is arguable whether the insurers improperly interpreted the plan, misinterpretation does not amount to the misrepresentation necessary to support an equitable estoppel claim.

This court has neither adopted nor rejected an equitable estoppel rule in the ERISA context. In *Averhart v. U.S. West Management Pension Plan*, 46 F.3d 1480 (10th Cir. 1994), we effectively avoided a decision of this issue by not explicitly saying an equitable estoppel theory was viable, but concluding the plaintiffs failed to state such a claim. We explained:

> We hold that, in any event, the plaintiffs have not shown any viable basis for the estoppel theory they advance – that there were representations made interpreting ambiguous Plan terms. Courts that have recognized estoppel claims in these circumstances have done so only where "the terms of the plan are ambiguous"

> and "the employer['s] communications constituted an interpretation of that ambiguity."

Id. at 1486 (citations omitted). Because Mr. Cannon has failed to state an equitable estoppel claim here, we do not believe this is a case in which the availability of such a claim should be decided.

AFFIRMED.

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF OKLAHOMA

JERRY, CANNON, Plaintiff, v. GROUP HEALTH SERVICE OF OKLAHOMA, INC., et al., Defendants.	)	No. CIV-94-159-A

ORDER

(Filed Sep. 2, 1994)

Before the Court are Plaintiff's Motion to Remand filed February 23, 1994, Defendants' Motion to Dismiss and/or For Summary Judgment filed July 13, 1994, and Plaintiff's Motion to Amend filed August 8, 1994. After carefully reviewing the parties' briefs and the evidentiary materials presented, the Court rules as follows.

A. MOTION TO REMAND

Plaintiff filed this suit in state court to recover damages for the death of his wife, who suffered from acute myeloblastic leukemia. Plaintiff alleged that defendants either negligently or in bad faith refused to authorize an autologous bone marrow transplant at a time when it offered the decedent a substantial chance of cure. Defendants removed the case on the basis of federal question jurisdiction, asserting that the decedent's health insurance benefits were part of an employee welfare benefit

plan governed by the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001 *et seq.* (ERISA), and that plaintiff's state law claims were thus preempted.

For the reasons stated below, the Court has determined that plaintiff's motion to remand this case to state court must be denied. Undisputed facts clearly establish that decedent Phyllis Cannon's group health insurance coverage was provided under an ERISA plan. Therefore, any claim related to the denial or untimely processing of decedent's claim for benefits arises under federal law, and this case was properly removed to federal court.[1]

Plaintiff admits that the decedent's insurance coverage "was provided to her as a benefit of her employment with Hendershot Tool Company." Brief in Support of Plaintiff's Motion to Remand, at 1. Nevertheless, plaintiff asserts that ERISA does not apply. Plaintiff argues that the health insurance program at issue was not an "employee welfare benefit plan" as defined by ERISA because it was not "established or maintained" by the decedent's employer. *See* 29 U.S.C. § 1002(1). Plaintiff contends that the employer, Hendershot Tool Company ("Hendershot"), merely purchased prepackaged insurance products that defendants created and marketed to numerous companies and that Hendershot did not intend

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[1] In plaintiff's initial brief in support of remand, he argued that even if ERISA preempted his claims, ERISA preemption could not provide a basis for removal under the well-pleaded complaint rule, which bars removal when a federal question is raised only in defense. This argument ignores the holding of *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66-67 (1987), and clearly lacks merit.

to establish an ERISA plan. Plaintiff's argument is contrary to statutory and decisional ERISA law.[2]

Plaintiff's position that Hendershot simply served as a conduit for defendants to sell their insurance policies lacks any factual basis. The following facts are undisputed: (1) Hendershot decided to provide health benefits for its employees and to fund those benefits through the purchase of group insurance; (2) Hendershot chose which insurance carrier to use and what package to buy; (3) Hendershot paid the full cost of insurance premiums; and (4) Hendershot designated one of its employees to explain the insurance program to new employees, to assist in enrolling new employees, to respond to employees' questions, and to handle other administrative matters. These facts are alone sufficient to show that Hendershot established an employee welfare benefit plan, even though Hendershot may have been ignorant of ERISA and even though defendants may have provided all documentation and all claims administration. *See Peckham v. Gem State Mutual*, 964 F.2d 1043, 1047-49 (10th Cir. 1987); *Roe v. General American Life Ins. Co.*, 712 F.2d 450, 451-52 (10th Cir. 1983); *see also Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 242-43 (5th Cir. 1990); 29 C.F.R. § 2510.3-1(j).

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[2] Alternatively, plaintiff asks this Court to create an exception to ERISA preemption under the alleged facts of this case. Plaintiff complains that ERISA does not provide him an adequate remedy and that insulating defendants from liability for their alleged conduct is unfair and unwise. This Court, however, cannot change the balance struck by Congress in enacting ERISA or overrule binding precedent.

Because the decedent's claim for health benefits was governed by ERISA, the law is clear that ERISA preempts all claims contained in plaintiff's original pleading, as well as all common law claims proposed to be added by amendment. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987) (bad faith, breach of fiduciary duty and fraud claims based on improper processing of plan claims were preempted); *Pitman v. Blue Cross & Blue Shield*, 24 F.3d 118, 121 (10th Cir. 1994) (tortious breach of contract claim); *Kelso v. General American Life Ins. Co.*, 967 F.2d 388, 390-91 (10th Cir. 1992) (misrepresentation claim); *Peckham*, 964 F.2d at 1050-51 (bad faith and estoppel claims); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509-10 (10th Cir. 1991) (tort of outrage, fraud and wrongful death claims). This being so, federal jurisdiction undoubtedly exists and removal was proper.

B. MOTION FOR SUMMARY JUDGMENT AND MOTION TO AMEND

Defendants' have moved for summary judgment based on their position that ERISA preempts all state law claims arising from their alleged denial of benefits in a negligent or bad faith manner and based on plaintiff's position that ERISA affords him no remedy (*see supra* note 1). Alternatively, defendants request a ruling that plaintiff cannot recover any of the compensatory or punitive damages he has demanded for any claim he may make under ERISA. *See Pilot Life*, 481 U.S. at 54; *Mertens v. Hewitt Associates*, 124 L. Ed. 2d 161, 170-71 (1993); *LaFoy v. HMO Colorado*, 988 F.2d 97, 99-100 (10th Cir. 1993).

Plaintiff has responded to defendants' motion by arguing that he has state law claims other than those contained in his original pleading that are not preempted. Accordingly, plaintiff has moved to file an amended pleading to include additional state claims. Defendants have responded to plaintiff's motion by both opposing the proper amendment and by replying to plaintiff's response to their summary judgment motion. Thus, these two motions will be addressed together.

1. SUMMARY JUDGMENT

Having determined that ERISA preempts all state common law claims asserted or proposed to be asserted by plaintiff, defendants' motion for summary judgment raises a purely legal issue: Whether plaintiff's proposed state statutory claims are preempted as well. Plaintiff contends that potential claims under statutes prohibiting unfair and deceptive insurance practices (Okla. Stat. tit. 36, §§ 1201-20, 1251-60, 4501-10 and tit. 63, § 2510) and other sections of the Oklahoma Insurance Code (Okla. Stat. tit. 36, §§ 3601 *et seq.*) are not preempted because they involve the regulation of insurance and thus are protected by ERISA's "saving clause," 29 U.S.C. § 1144(b)(2)(A).

The state statutes on which plaintiff proposes to base his new claims are not laws that regulate insurance within the meaning of ERISA's saving clause. In *Pilot Life*, 481 U.S. at 48-49, the Supreme Court used the test of whether a practice falls under the "business of insurance" as defined by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*, to determine whether a law falls within the

saving clause. Accordingly, a state law cause of action must meet three criteria in order to regulate insurance and to be beyond ERISA's reach: (1) the law has the effect of transferring or spreading a policyholder's risk; (2) the law is an integral part of the relationship between insurer and insured; and (3) the law is limited to entities within the insurance industry. *See Pilot Life*, 481 U.S. at 48-49; *see also Kelso*, 967 F.2d at 391.

None of the statutes relied on by plaintiff satisfy the "business of insurance" criteria for exclusive state regulation. Statutes that prohibit and remedy unfair and deceptive insurance practices (Okla. Stat. tit. 36, §§ 1201-20, 1251-60, 4501-10 and tit. 63, § 2510) and statutes that require insurance policies to contain certain information (Okla. Stat. tit. 36, §§ 3613-14) neither effect policyholders' risk nor are an integral part of the insurance relationship. The Tenth Circuit has so held. *See Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453, 456 (10th Cir. 1989) (involving a similar Colorado statute).[3] Plaintiff points to no statute implicated by his factual allegations that regulates the substantive terms of insurance contracts like other statutes that fall within ERISA's saving clause. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (mandated-benefits statute); *Blue Cross & Blue Shield v. Bell*, 798 F.2d 1331 (10th Cir. 1986) (mandated-

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[3] The Court notes that its decision is contrary to dicta in *Easley v. Oklahoma State & Educ. Employees Group Ins. Bd.*, 838 P.2d 541 (Okla. Ct. App. 1992). Of course, that decision is not binding on this court because state law affords *Easley* merely persuasive and not precedential value (*see* Okla. Stat. tit. 12, chap. 15, App. 2, Rule 1.200(C)), and because it also appears to be contrary to Tenth Circuit law.

providers statute). Therefore, the Court concludes that all statutory claims plaintiff seeks to add by amendment are preempted by-ERISA.

Summary judgment should be granted where there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). Because ERISA bars all state law claims asserted in plaintiff's original pleading or sought to be added by amendment, and because plaintiff apparently concedes that his factual allegations fail to state a claim under ERISA, defendants are entitled to summary judgment in their favor on all claims presently asserted against them.

2. AMENDMENT OF PLAINTIFF'S PLEADING

Because all state law claims plaintiff seeks to add by his amended pleading could not withstand a motion to dismiss, the requested amendment would be futile. Under that circumstance, permission to file an amended pleading need not be granted. *Frank v. U.S. West, Inc.*, 3 F.3d 1357, 1365 (10th Cir. 1993); *Castleglen, Inc. v. Resolution Trust Corp.*, 964 F.2d 1571, 1585 (10th Cir. 1993); *Schepp v. Fremont County*, 900 F.2d 1448, 1451 (10th Cir. 1990). Accordingly, plaintiff's pending motion to amend his original petition will be denied. This ruling does not foreclose the possibility, however, that plaintiff may seek to assert a federal claim, of some nature presently unknown to the Court, against defendants arising from the underlying facts of this case.

For these reasons, Plaintiff's Motion to Remand is DENIED, Defendants' Motion to Dismiss and/or for

Summary Judgment is GRANTED, and Plaintiff's current Motion to Amend is DENIED. However, plaintiff may move for permission to file an amended complaint within twenty (20) days after the date of this order.

It is so ordered this 2nd day of September, 1994.

/s/ Wayne E. Alley
WAYNE E. ALLEY
United States District Judge

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF OKLAHOMA

JERRY CANNON, individually, and on behalf of the Estate of PHYLLIS CANNON, deceased, Plaintiff, v. GROUP HEALTH SERVICE OF OKLAHOMA INC., d/b/a BLUE CROSS & BLUE SHIELD OF OKLAHOMA; and GHS HEALTH MAINTENANCE ORGANIZATION, INC., d/b/a BLUE LINCS HMO, Defendants.	)	No. CIV-94-159-A

ORDER

(Filed Dec. 8, 1994)

Before the Court is plaintiff Jerry Cannon's motion to amend his complaint, filed September 22, 1994. The motion has now been fully briefed, and the Court rules as follows.

Plaintiff filed this suit in state court to recover damages for the death of his wife, who suffered from acute myeloblastic leukemia. Plaintiff alleged that defendants negligently or in bad faith refused to authorize an autologous bone marrow transplant (ABMT) in a timely manner. Defendants removed the case based on federal question jurisdiction, asserting that plaintiff's state law claims were preempted by the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001 *et seq.* (ERISA),

because the decedent's health insurance was part of an employee welfare benefit plan.

The Court has previously ruled that decedent Phyllis Cannon's group health insurance coverage was provided under an ERISA plan, and thus, any claim related to the denial or untimely processing of decedent's claim for benefits arises under federal law. The Court has also ruled that ERISA bars all state law claims asserted in plaintiff's original pleading or proposed by a previous motion to amend. Although plaintiff earlier argued that ERISA afforded him no remedy, the Court has given plaintiff an opportunity to assert whatever federal theory of relief might be available to him. He now seeks to file claims under ERISA and the Lanham Trade-Mark Act, 15 U.S.C. §§ 1051 *et seq.*

In response, defendants assert that plaintiff's motion to amend should be denied because the proposed complaint fails to state a claim upon which relief can be granted. According to defendants, plaintiff has no claim for benefits under ERISA because the medical treatment his wife desired was never provided and thus no medical expenses were incurred. Defendants also assert that plaintiff has no breach of fiduciary duty claim under ERISA because such a claim can only be asserted on behalf of a plan, not a plan beneficiary. Finally, defendants say that plaintiff lacks standing to sue under the Lanham Act because it is a trademark law designed to protect businesses from unfair competition and not to protect consumers from false advertising. *See Colligan v. Activities Club of New York Limited,* 442 F.2d 686 (2d Cir. 1971); 15 U.S.C. § 1127.

Because defendants' response amounted to a dispositive motion, the Court invited plaintiff to reply. Plaintiff has now done so. For the reasons explained below, the Court finds unavailing plaintiff's efforts to avoid his prior concession that ERISA gives him no remedy and to create a misrepresentation claim under the Lanham Act.

ERISA

Plaintiff asserts that he can prosecute three types of claims under ERISA: one for benefits under 29 U.S.C. § 1132(a)(1); one for equitable relief under 29 U.S.C. § 1132(a)(3); and one for breach of fiduciary duty under 29 U.S.C. §§ 1132(a)(2) and 1109. Each of these claims will be addressed in turn.

Claims for Benefits and Equitable Relief

It is undisputed that defendants authorized ABMT for the decedent too late and she never actually received ABMT or incurred any medical expenses for it. Nevertheless, plaintiff argues that he should recover damages in the amount of the value of ABMT (allegedly, $200,000) as an unpaid benefit that the decedent was entitled to under the ERISA plan. Plaintiff's argument is contrary to statutory and decisional ERISA law.

The terms of the employee welfare benefit plan sponsored by decedent's employer appear, as far as is pertinent here, in a group health insurance contract or policy. Its benefits included either pre-paid health services received from a participating medical provider or, in some situations, reimbursement for the reasonable cost of

care provided by a non-participating medical provider. By definition, then, a plan beneficiary must have actually received medical treatment or care in order to obtain a benefit.

Under ERISA's civil enforcement scheme, a plan participant or beneficiary may sue "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Under this statutory provision, "[r]elief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53 (1987). Under subsection 1132(a)(3), a plan participant or beneficiary may seek "other appropriate equitable relief". However, that term does not include money damages, that is, monetary relief for losses sustained, "the classic form of *legal* relief." *Mertens v. Hewitt Associates*, 508 U.S. ___, 124 L. Ed. 2d 161, 169 (1993) (emphasis original); *see also LaFoy v. HMO Colorado*, 988 F.2d 97, 99-100 (10th Cir. 1993).

The Court has carefully considered plaintiff's argument but stands unpersuaded that he can sue under subsection 1132(a)(1) or (3) to recover anything other than payment for medical expenses actually incurred, when that is the benefit provided by the plan. Plaintiff cites no legal authority for the proposition that a person may sue to recover the value of a service that would have been a benefit of the plan if the plan's terms had been satisfied. The Court has found no such authority and does not believe that it should expand the benefits

expressly provided by the plan in that way, simply because plaintiff may have no remedy under the peculiar and unfortunate facts of this case. Otherwise, a plan beneficiary could claim a right to be paid for unperformed medical services anytime pre-authorization for the service was obtained.

Breach of Fiduciary Duty

The civil enforcement provisions of ERISA also authorize suit by a participant or beneficiary for breach of fiduciary duty, but the beneficiary cannot personally recover compensatory damages in such a case. A fiduciary is liable under ERISA, if at all, to the plan and not to the beneficiary. *See Mertens,* 124 L. Ed. 2d at 167; *Massachusetts Mut. Life Ins. Co. v. Russell,* 473 U.S. 134, 140. Under ERISA, a beneficiary whose claim for benefits is wrongfully denied may sue to recover benefits and, under some circumstances, may sue for removal of the fiduciary. *Russell,* 473 U.S. at 146-47. He may not, however, use a breach of fiduciary duty theory to recover money not due him under the terms of the plan. *Id.* at 148; *LaFoy,* 988 F.2d at 99-100.

The Tenth Circuit has recently decided a case that the Court finds instructive. In *Pitman v. Blue Cross & Blue Shield,* 24 F.3d 118 (10th Cir. 1994), the plaintiff was covered under an employer's group health insurance policy. Blue Cross and Blue Shield of Oklahoma refused preauthorization for ABMT, and the plaintiff received it only because family and friends raised enough money to meet the hospital's threshold payment requirements. The district court found that ERISA preempted the plaintiff's

state law claims of tortious breach of contract and insurer's bad faith and that no ERISA breach of fiduciary duty claim could be maintained on the undisputed facts. The district court entered summary judgment against the plaintiff, and his widow prosecuted an appeal to the Tenth Circuit when he died.

The Tenth Circuit construed the plaintiff's ERISA claim as one to recover benefits under the insurance policy rather than one for breach of fiduciary duty. *Pitman*, 24 F.3d at 120-21. Concerning the latter, the Tenth Circuit noted the "inartfully styled" claim sought money that would inure to the plan so that it could be used to reimburse his claim, but what the plaintiff really wanted was payment for benefits wrongfully denied. *Id.* at 121 n.7. The Tenth Circuit relied on another case in which a request for injunctive relief to permit the plaintiff to receive ABMT was construed as a claim for benefits due, "recognizing that any recovery for breach of fiduciary duty under [ERISA] would make the . . . administrator liable to the group health plan, but only the plan liable for providing the coverage." *Id.* (citing *Leonhardt v. Holden Business Forms Co.*, 828 F. Supp. 657, 663 (D. Minn. 1993)).

Pitman teaches that a claim for wrongful refusal to authorize ABMT treatment, although phrased as one for breach of a fiduciary duty, is one to recover plan benefits. If that is the claim, and if the plan beneficiary can neither be reimbursed for an incurred expense nor receive ABMT, then no relief is available, as discussed above.[1]

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[1] Such a role does not make an insurer immune from suit under ERISA nor deprive persons who are denied pre-

LANHAM TRADE-MARK ACT

Plaintiff claims a right to recover under the Lanham Act for defendants' use of an allegedly false marketing slogan: "quality health care at an affordable price". The Tenth Circuit has not decided whether consumers may sue a seller of goods or services for false representation under the Lanham Act, 15 U.S.C. § 1125(a). Defendants urge the Court to adopt a view from other circuits that limits standing to a commercial class of plaintiffs and requires a plaintiff under section 1125(a) to be, if not a competitor, at least one who has a potential for commercial or competitive injury. *See Berni v. International Gourmet Restaurants of America, Inc.*, 838 F.2d 642, 648 (2d Cir. 1988). Plaintiff, in turn, urges the Court to adopt the "reasonable interest" test that other circuits have used to determine standing, *see, e.g., Thorn v. Reliance Van Co.*, 736 F.2d 929, 933 (3d Cir. 1984); *Smith v. Montoro*, 648 F.2d 602,

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authorization for ABMT under an ERISA-governed insurance policy of any remedy, although it has that effect under the unique circumstances of this case. The Tenth Circuit in *Pitman* reversed the summary judgment in favor of the insurer and remanded the case for further review of the plaintiff's claim, ruling that when an insurer stands to profit from a coverage decision, its decision is not entitled to review under the deferential standard ordinarily applied. *Pitman*, 24 F.3d 122-23. Thus, when an insurer/ERISA plan administrator wrongfully denies coverage for a service, the insured has a remedy. He may sue for injunctive relief or find another source of payment and sue for reimbursement. Unfortunately, in this case, Mrs. Cannon did neither, and her personal circumstances may have prevented her from doing so. However, that ERISA's civil enforcement scheme may yield harsh results in individuals cases is no justification for judicial legislation. *See Mertens*, 124 L. Ed. 2d at 172.

608 (9th Cir. 1981), and that at least one court has used to permit suit by "ultimate consumers" of a product with false packaging, *Maguire v. Sandy Mac, Inc.*, 138 F.R.D. 444, 446 (D.N.J. 1991).

Under the facts of this case, the Court finds that it need not reach the consumer standing issue. Even under plaintiff's view of the Lanham Act, the Court finds that he lacks standing to sue under section 1125(a).

Determining standing under the test advocated by plaintiff requires a determination that the party has a reasonable interest to be protected against false advertising and has alleged a sufficiently direct injury resulting from the advertising at issue. *Thorn*, 736 F.2d at 933. Assume that a "reasonable interest" to be protected against the advertising at issue here are those who would be influenced by the slogan, "quality health care at an affordable price", to purchase defendants' group health insurance policies. Undisputed facts shown by defendants' previous motion for summary judgment are that the decedent's employer, Hendershot Tool Company, chose which insurance carrier to use for its health insurance program and what insurance package to buy, and Hendershot paid the full cost of insurance premiums for its employees. *See* Order of September 2, 1994, at 3. The Court believes the injury alleged by plaintiff, that the decedent was influenced to enroll in her employer's health insurance program, is too tenuous to bring her within the protection of the Lanham Act.

CONCLUSION

Because the federal claims plaintiff seeks to plead could not withstand a motion to dismiss, his proposed amendment would be futile. Under that circumstance, permission to file an amended pleading need not be granted. *Frank v. U.S. West, Inc.*, 3 F.3d 1357, 1365 (10th Cir. 1993); *Castleglen, Inc. v. Resolution Trust Corp.*, 964 F.2d 1571, 1585 (10th Cir. 1993); *Schepp v. Fremont County*, 900 F.2d 1448, 1451 (10th Cir. 1990). Accordingly, plaintiff's pending Motion to Amend is DENIED.

Because the Court has previously granted summary judgment to defendants on all claims asserted in plaintiff's original pleading and because no amended pleadings have been permitted, the Court's summary judgment ruling is dispositive of the case. Accordingly, judgment will be entered in favor of defendants Group Health Service of Oklahoma, Inc. d/b/a Blue Shield & Blue Cross of Oklahoma, and GHS Health Maintenance Organization, Inc., d/b/a Blue Lincs HMO.

It is so ordered this 8th day of December, 1994.

/s/ Wayne Alley
WAYNE E. ALLEY
United States
District Judge

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF OKLAHOMA

JERRY CANNON, individually, and on behalf of the Estate of PHYLLIS CANNON, deceased, Plaintiff,	)	No. CIV-94-159-A
v.	)	
GROUP HEALTH SERVICE OF OKLAHOMA INC., d/b/a BLUE CROSS & BLUE SHIELD OF OKLAHOMA; and GHS HEALTH MAINTENANCE ORGANIZATION, INC., d/b/a BLUE LINCS HMO, Defendants.	)	

JUDGMENT

(Filed Dec. 8, 1994)

Pursuant to the Order issued on September 2, 1994, granting defendants' motion for summary judgment, judgment is hereby entered in favor of defendants Group Health Service of Oklahoma, Inc. d/b/a Blue Shield & Blue Cross of Oklahoma, and GHS Health Maintenance Organization, Inc., d/b/a Blue Lincs HMO and against plaintiff Jerry Cannon, individually, and on behalf of the Estate of Phyllis Cannon, deceased.

Entered this 8th day of December,1994.

/s/ Wayne E. Alley
WAYNE E. ALLEY
United States
District Judge

CONSTITUTIONAL PROVISIONS:

The Fifth Amendment to the United States Constitution

> "No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use without just compensation."
>
> U.S. Const. amend. 5.

The Ninth Amendment to the United States Constitution

> "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."
>
> U.S. Const. amend. 9.

The Tenth Amendment to the United States Constitution

> "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."
>
> U.S. Const. amend. 10

The Fourteenth Amendment to the United States Constitution

"Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are

citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property; without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

U.S. Const. amend. 14

Oklahoma Const. Art. 2, Sec. 6.

"The courts of justice of the state shall be open to every person, and speedy and certain remedy afforded for every wrong and for every injury to person, property or reputation; and right and justice shall be administered without sale, denial, delay or prejudice."

Oklahoma Const. Art. 2, Sec. 7.

"No person shall be deprived of life, liberty, or property, without due process of law."

STATUTES AND OTHER AUTHORITIES:

Employee Retirement Income Security Act of 1974, Section 2(b)

> (b) It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct,

responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

29 U.S.C. § 1001(b)

Employee Retirement Income Security Act of 1974, Section 502(a)

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1009 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (I) to redress such violation or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025 (c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (I) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (I) of this section.

29 U.S.C.§ 1132 (a).

Article 40 of Magna Carta

"To none will we sell, to none will we deny, to none will we delay right or justice."

Magna Carta, Art. 40.